

Cancer Registry Review

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ACR ANNOUNCEMENTS

VERSION 01.04.00 COLLABORATIVE STAGING MANUAL

This information elaborates on the email that was sent out to Arizona registrars on February 8th. This article is for informational purposes only. Do not begin using the new version until instructions are issued by the ACR.

When

The updates to the manual were issued on October 31st, 2007.

Why

The Collaborative Staging task force is charged with making improvements to the manual in order to capture the most complete and accurate information possible. Correctly describing the extent of disease at diagnosis for patients who undergo neoadjuvant treatment is an important focus of version 01.04.00.

The new edition includes enhancements to schemas for stomach, colon, rectum, and breast. Patients with these malignancies commonly receive preoperative radiation and/or systemic therapy. Site Specific Factor 2 for the colon and rectum schemas and SSF 1 for the stomach schema address the status of clinically assessed regional lymph nodes. The CS Lymph Nodes item for the breast schema has been updated to allow for the collection of information on clinical regional lymph node status.

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ACR ANNOUNCEMENTS

ACKNOWLEDGEMENTS

The ACR wishes to congratulate Arizona's newest CTR's!

- ♦ Ardis A. Decker Arizona Cancer Registry
- ♦ Andrea S. Follows Mayo Clinic
- ♦ Jill L. Ialenti Arrowhead Community Hospital
- ♦ Li-Min Sun Banner Good Samaritan Medical Center
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ACR ANNOUNCEMENTS

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Where

You may access general and detailed information about Version 01.04.00 from the official Collaborative Staging web site, <http://www.cancerstaging.org/cstage/index.html>

What to Do

Registrars do not need to take any action at this time. *Do not implement the changes until you receive detailed information from the ACR.* However, until you receive specific instructions, you may want to review the changes and make preparations for updating your manual. The ACR will not be distributing the updated manual pages. You may download them from the official Collaborative Staging web site. <http://www.cancerstaging.org/cstage/manuals.html>. You have the option of printing off the entire manual, or just the replacement pages (A heads-up that there are more than 200 new pages).

Revised Commission on Cancer Standard for TNM Staging Requirements

The American College of Surgeons' Commission on Cancer has revised standard 4.3 of the Cancer Program Standards: "Staging appropriate to the category is assigned by the managing physician, or other approved medical professional, and is recorded in a standardized location in the medical record for 90% of eligible annual analytic cases." The change was made due to problems with standard implementation and compliance.

A streaming video presentation is available through the College's web site that explains the changes in detail. You may access this free of charge at <http://www.facs.org/cancer/coc/webconf8.html>.

What the Revised Standard Means for College-Approved Programs

Requirements for TNM staging by physicians have been updated. Previously, the CoC required that T, N, and M be recorded in the medical record by the patient's managing physician, or other designated medical professional. Beginning with cases diagnosed January 1, 2008, it is no longer required that a physician complete

TNM staging. The College still encourages this practice even though it no longer mandates it. When clinical T, N, M, and stage group information is not obtainable from a physician, the registrar must record it in the abstract. A (very) brief summary of the updated requirements includes:

Each facility's cancer committee will develop and implement two processes:

1. Evaluate the accuracy of the Collaborative Stage derived stage.
2. Promote and document physician use of AJCC TNM Staging in treatment planning.

Additionally, pathologic TNM staging will no longer be required. This is because it is considered to be adequately captured by the Collaborative Staging data items.

A comprehensive discussion of these changes can be found in a special announcement posted by the College. You may download the document from <http://www.facs.org/cancer/cannews.html>. Also, updated *Cancer Program Standards 2004, Revised Edition* pages, showing the changes to Standards 4.3 and 2.10 are available online at <http://www.facs.org/cancer/coc/programstandards.html>.

What the Revised Standard Means for All Programs

The ACR does not require that physicians complete TNM staging, and so the change has no impact on the ACR's requirements. However, even if your cancer program is not approved by the CoC, this update will have a few implications for your registry.

First, the standard edits will be modified at a later date to reflect the updated standard. These edits updates are not currently available. A revised set of EDITS will be released at a later date. Second, the College has issued temporary replacements for FORDS pages 20, 21, 112 to 123, and 289, 290, and 295-297. The updated pages are available for download from <http://www.facs.org/cancer/coc/fordsmanual.html>, under the heading "Update 2008." The ACR will issue a fresh set of labels for these pages. The content of the labels will not be changed.

Note- You may hold off on inserting the pages until you are ready to begin abstracting 2008 cases. These changes are effective for cases diagnosed on/after 1/1/2008.

REGISTRAR EDUCATION

UPCOMING CONFERENCES/ WORKSHOPS

NCRA Conference

The National Cancer Registrar's Association 34th annual educational conference will be held in Minneapolis, Minnesota from April 29th through May 1st. The theme will be "Educating & Advocating for Cancer Registrars." Go to NCRA's web site, <http://www.ncra-usa.org/conference/registration.htm> to obtain a full conference schedule and to register. Several registration packages are available.

St. Joseph's Hospital Conference

The educational conference "Spring in to Action—Cancer Treatment Planning Educational Workshop" will be held on Monday, March 31st, at St. Joseph's Hospital in Phoenix. A business meeting for the Cancer Registry Association of Arizona (CRAAZ) will also be held. Program information and registration forms were recently sent out via email. For additional information, contact Valerie Vesich at 602-406-3048 or Valerie.Veisch@chw.edu.

Be Part of the Collaborative Staging Reliability Study and Earn CE's!

SEER will be conducting a reliability study that will re-test the Collaborative Staging Manual. SEER has requested continuing education units from the National Cancer Registrars Association.

What does the study involve?

You will be assigned to code Collaborative Staging data items for four (4) cases from the following sites: Breast, Colon, Lung and Prostate – a total of 16 cases.

When and where will the study take place?

This study will be conducted on the NCI SEER website. The reliability study will open for participants to register and code the **prac-**

tice cases (1 for each of the 4 sites) at 8 AM Eastern time on Monday, March 3. The website will be open for participants to do the **study cases** at 8 AM Eastern time on Monday, March 17. The website will be closed at 8 AM on Monday, March 31.

How do I sign up?

The website will be available for registration at 8 AM Eastern time on March 3, 2008. Go to the website <https://seer.cancer.gov/reliability> to register for the study (please note: this website will not be available until 8 am on March 3, 2008). You will create an account by entering your name, a username of your choice, and a password that you can remember. Your username must be at least four characters long and may be alpha, numeric, or alphanumeric. The password must be at least six characters in length and may be alphabetic, numeric, or alphanumeric. You will also be asked to enter a contact telephone number and email address.

When you have completed this information, click the Register button. This will take you to the log-in page. Your username will appear in the sign-in box. Enter your password. Click on "My Account" on the menu bar. You will be prompted to enter your demographic information. This information must be completed before you will be allowed to access the study cases. If any of the items are incomplete, an error message will appear in red on the top of the page. Please read the error message and fill in the missing information.

A registration confirmation will be sent to your email address. Please keep this confirmation for reference.

Who will show me how to use the software?

After you log-in to the website, you will be able to download a User's Guide. The website will open March 3, 2008 at 8 AM Eastern to allow participants to work on practice cases before the actual study begins. It is recommended that you code the practice cases to

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REGISTRAR EDUCATION

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become familiar with the study site and the software before doing the study cases.

Important: Please remember that you must enter your information in “My Account” before you can access the 16 study cases.

Important dates to remember

March 3, 2008 8 AM ET Website open for registration
March 3, 2008 8 AM ET Website open for participants to do practice cases
March 17, 2008 8 AM ET Website open for participants to do study cases
March 31, 2008 8 AM ET Website closed

For further information, please contact Jennifer Ruhl at ruhlj@mail.nih.gov.

Online Educational Opportunities

The Commission on Cancer sponsors a series of web-based educational sessions that can be viewed at your convenience. A complete listing of programs can be found at <http://www.facs.org/cancer/webcast/index.html>.

Topics beneficial for all registrars, whether or not they work in College-approved programs, include:

- Breast Cancer Staging: What Registrars Need to Know
- Colorectal Cancer Staging: What Registrars Need to Know
- Lymphoma Staging: What Registrars Need to Know

(The three programs listed above focus on TNM staging).

- Collaborative Staging: Breast Cancer
- Collaborative Staging: Colorectal Cancer
- Collaborative Staging: Lung Cancer
- Collaborative Staging: Prostate Cancer
- FORDS: A Series of Inquiry and Response (I&R) System Questions and Answers

The Collaborative Staging sessions are free of charge. The other sessions cost \$50 for programs that are not approved by the CoC (\$30 for approved programs).

The National Cancer Registrar's Association has awarded CE's for each Web cast. All programs offering credit require you to complete a post-test with 100% accuracy and a program evaluation form. Simply viewing a program does not make an individual eligible for CE credits.

Educational CD's for Purchase from NCRA

The National Cancer Registrars Association (NCRA) offers several educational, multimedia CD's for purchase:

NCRA's CTR Exam Prep Workshop CD

Fee: \$150/ NCRA member
\$185/non-member

NCRA's 2007 Fundamentals of Abstracting for New Cancer Registrars Workshop CD

Fee: \$200/NCRA member
\$250/non-member

NCRA's 2007 Multiple Primary and Histology Coding Rules Workshop on CD (2007)

\$75/NCRA member
\$115/non-member

If you are interested, go to <http://www.ncra-usa.org/store/index.htm> and scroll down to the heading “Multimedia Products” for details.

REGISTRAR EDUCATION

North American Association of Central Cancer Registries (NAACCR) Hospital Webinar Series

The schedule for the remainder of the 2008 season is as follows:

- | | |
|------------------|--|
| 2/14/2008 | Cancer Treatment and How to Code It: Surgery, Radiation, Systemic, and Other |
| 3/6/2008 | Abstracting Thyroid Cancer Incidence and Treatment Data and Abstracting Larynx Cancer Incidence and Treatment Data |
| 5/8/2008 | Data Quality and Data Use |
| 7/10/2008 | Abstracting Upper Gastrointestinal Tract Cancer Incidence and Treatment Data |
| 9/11/2008 | Abstracting Other Digestive System Cancer Incidence and Treatment Data |

The ACR purchased a single subscription for this series, instead of the three that were purchased for the 2007 series. Sessions will be held at the ACR. Registrars who are unable to come to Phoenix may purchase the sessions for \$180 per session.

North American Association of Central Cancer Registries (NAACCR) Central Registry Webinar Series

The schedule for the remainder of the 2008 central registry season is listed below. These sessions are geared towards central registry staff:

- | | |
|------------------|---|
| 2/21/2008 | Record Linkage and Record Consolidation |
| 3/13/2008 | Central Registry Quality Assurance Activities
Collecting Cancer Surveillance Data from Non-Hospital Sources |
| 4/10/2008 | Cancer Surveillance Data Use and Release
Overcoming the Hurdles to Using Cancer Surveillance Data in Research
The News Media and Cancer Surveillance Data |
| 5/15/2008 | Analyzing and Presenting Cancer Surveillance Data |
| 6/19/2008 | Thyroid Cancer Surveillance Data Collection; Larynx Cancer Surveillance Data Collection |
| 7/17/2008 | Upper Gastrointestinal Tract Cancer Surveillance Data Collection |
| 8/21/2008 | Syntactic and Semantic Interoperability Project |
| 9/18/2008 | Death Clearance Procedures |

CODING CORNER

Reportability/Class of Case

Question

Breast cancer was diagnosed and treated at another facility. The patient underwent a modified radical mastectomy elsewhere, then presented here for reconstructive surgery. Is the case reportable?

Answer

American College of Surgeons' I&R 13108 10/19/04 addresses a similar question:

A breast cancer patient was diagnosed and treated at another facility in 2003. She came to our facility for the planned reconstruction. Do we need to accession the case? If so, how do we code surgical procedure at this facility?

As the reconstruction was planned as part of first course of treatment, this would be a class 2 case and an abstract containing required data fields must be completed. Reconstruction is coded 53-63.

Cancer Identification

Date of Inpatient Admission

The Date of Inpatient Admission field is one of the data items used to help track abstracting timeliness. A reminder that there is a hierarchy of rules when coding date of inpatient admission.

1. Date of the inpatient admission to the reporting facility for the most definitive surgery.
2. If there was no surgery, use the date of inpatient admission for any other cancer-directed therapy.

3. If there was no cancer-directed therapy, use the date of inpatient admission for diagnostic evaluation.

4. When the patient was admitted with evidence of cancer, and none of the above (1-3) apply, use the date the patient was admitted with evidence of disease.

For non-analytic cases, use the date the patient enters your facility with evidence of disease.

Primary Site & Histology

Question

Patient was diagnosed with CLL/SLL (Chronic lymphocytic leukemia/small lymphocytic lymphoma). The physicians on the case refer to CLL throughout the record. Studies demonstrate widespread lymphadenopathy. How would site and histology be coded?

Answer

Consider the case to be small lymphocytic lymphoma (SLL) if there are positive lymph nodes or deposits of lymphoma/leukemia in organs or in other tissue. Code the site to the involved tissue (typically lymph nodes, lymphatic structures, breast, and stomach). Code histology to 9670/3.

Consider the case to be chronic lymphocytic leukemia (CLL) if there are no physical manifestations of the disease other than a positive blood study or positive bone marrow. Code the primary site to bone marrow (C42.1)

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and the histology to CLL (9823/3).

References: Johnson CH, Adamo M (eds.) SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007. Page 83.

SEER Program, NCI. Clarifications for Abstracting and Coding Hematopoietic Diseases. May 22, 2001.

Behavior Code

Question

Patient has a diagnosis of Paget's disease and intraductal carcinoma of the breast (histology code 8543/3). CS Extension was coded to 07 (Paget Disease of nipple (WITHOUT underlying invasive carcinoma pathologically). The derived T value is Tis. The case passes edits, but it does not make sense that a condition with a behavior code of "3" should map to Tis.

Answer

Note 4 for "CS Extension" in the breast schema states that "If extension code is 00, then Behavior code must be 2; if extension code is 05 or 07, then behavior code may be 2 or 3; and, if extension code is 10, then behavior code must be 3."

The histology code (8543/3), behavior code, and CS Extension code (07) are correct for this case.

Stage of Disease

Collaborative Staging Prostate Cancer—Site Specific Factor 2 Prostatic Specific Antigen Question

If a PSA value is not stated to be elevated or normal in the documentation, should I use the PSA value to determine if it's elevated or not?

Answer

Since normal PSA ranges vary by age and race, the registrar should not make a determination as to whether a PSA is elevated, normal, or borderline based on the value in the absence of a doctor's clinical judgment.

Collaborative Staging Prostate Cancer—Site Specific Factor 5 Gleason's Primary Pattern and Secondary Pattern Value Question

Patient had a prostate biopsy which showed adenocarcinoma, Gleason pattern 3+5=8 in one core from the right side of the gland. Tumor was present in 60% of the specimen. Biopsy taken from the left prostate showed adenocarcinoma, Gleason pattern 3+4, involving 10% of the specimen. Patient did not have surgery. Two Gleason patterns are given here. Which one do I use?

Answer

Use the pattern from the sample where tumor is present in 60% of the specimen (3+5)

Note 2 under Site Specific Factor 5 in the prostate schema (page 440 of the CS manual)

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states: “Following AJCC guidelines for coding multiple Gleason's Scores in prostate cancer, if there is more than one primary and secondary pattern value, the value to be coded is the one based on the larger tumor specimen. Please note that this rule is not the same as the rule for coding grade.”

If you have a biopsy and a specimen from a radical retropubic prostatectomy, it is pretty clear-cut that you would use the specimen from the prostatectomy to code SSF5. In this case, all the patient had was a biopsy. Use the Gleason pattern from the core where a greater percentage of the specimen is involved with malignancy.

See I&R #15564 from the American College of Surgeons' Inquiry and Response system:

Question

A sextant biopsy stated a Gleason pattern of 3+4 was given to the biopsies from the rt base (50% of specimen); rt mid (focus only); lt base (less than 1 mm); and rt lat horn (70% of specimen). There was also a Gleason pattern of 4+3 given to the biopsies from the lt apex (10% of specimen) and lt lat horn (80% of specimen). Since these are only biopsies, and 4 of the specimen's Gleason scores are 3+4, do we code as “034” or do we look at the largest individual specimen size, 80% lt lat horn, and code 4+3 = 043?

Answer

Code the Gleason score from the largest percent of the specimen: 043 (4+3 from 80% of specimen).

A Reminder to Non-RMCDS Hospitals

For the sake of consistency, the ACR has required that all hospitals that use software other than Rocky Mountain insert text information about other primary tumors in NAACCR field #2680, Text- Remarks, in the first line.



CODING CORNER— SPECIAL SECTION

This section discusses the most common EDITS found during recent quality assurance activities:

Issue- Incorrect Coding of Surg/Rad Seq Item (Page 164, FORDS 2007)

Error Message states: Conflict among surgery items, Rad—Regional RX Modality, RX Summ—Surg/Rad Seq

The field “Rad/Surg Sequence” is intended to capture information on whether radiation therapy was administered preoperatively, post-operatively, or intraoperatively. “Surgery” can refer to Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, and Surgical Procedure/Other Site.

If a patient underwent:

- Surgery, but did not have radiation therapy
- Radiation therapy, but did not undergo surgery
- Neither surgery nor radiation therapy

then Rad/Surg Sequence must be coded to “0.”

The following question submitted to the American College of Surgeons’ Inquiry and Response system illustrates this point:

18694

5/25/2006

If there was no radiation but surgery to the primary site was performed, what is the Radiation/Surgery Sequence code?

Per the Instructions for Coding for the Radiation/Surgery Sequence field, code to 0 if all other radiation fields have been coded to 0.

Relationship of “Scope of Regional Lymph Node Surgery” and “Surgical Procedure/Other Site” Items to “Rad/Surg Sequence”

An important principle to keep in mind is that surgery includes the items “Scope of Regional Lymph Node Surgery” and “Surgical Procedure/Other Site,” not just “Surgical Procedure of Primary Site.”

For instance, if a patient underwent biopsy or removal of regional lymph nodes but did not undergo surgery of the primary site, this is considered to be surgery according to the logic of the “Rad/Surg Sequence” item. Therefore, if the patient undergoes radiation, “Rad/Surg Sequence” cannot be coded to “0.”

Do not use code “9” for any of these situations. Use code “9” only if:

- The patient underwent both surgery and radiation therapy, but it is unknown which came first
- It is unknown if the patient underwent radiation, and/or it is unknown if the patient underwent surgery (See discussion below)

If no information is available about treatments, these fields are to be coded using 0’s. Do not leave any required fields blank. The following example, taken from the SEER Inquiry Web Site, touches upon this issue in the last sentence:

SINQ ID 20021181

Question

Radiation/Chemotherapy: How do we code radiation and chemotherapy when the only statement we have is that the patient is

CODING CORNER— SPECIAL SECTION

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"referred to either an oncologist or a radiation therapist"?

Answer

For cases diagnosed 1/1/2003 and after: A referral does not mean that the radiation therapy or chemotherapy was actually recommended. These cases need follow-back to see if treatment was recommended and/or administered. Some registries code these cases as 8 [Radiation recommended, unknown if administered] or 88 [Chemotherapy recommended, unknown if it was administered] and routinely review all cases with 8 or 88 codes. Upon review, the codes are updated depending on the information found. **If there is no information available, the code 8 or 88 is changed to 0 or 00 [None].**

Systemic/Surgery Sequence

Systemic/Surgery sequence follows the same guidelines as Surg/Rad Seq. This item must be coded for cases diagnosed on or after 1/1/2006. Use code "0" for cases where you have no documentation that the patient underwent both systemic therapy and any kind of surgical procedure (i.e., Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, and/or Surgical Procedure/Other Site).

The Importance of Consistency Between Codes and Text

A problem that is seen fairly frequently is a lack of consistency between coded and text information. For instance, information about cancer treatment may be recorded in text

fields, but coded information is missing. Conversely, abstracts frequently contain codes without corroborating text. It is very important that both text and codes are included in an abstract.

Issue- Incorrectly Coding Primary Site for Meningiomas to a Brain Subsite

Error Message states: Site & Morphology Conflict – ICDO3

Code the primary site for a tumor with a meningioma histology code (9530-9539) to a meninges site (C70.0, C70.1, or C70.9 as appropriate), rather than a brain site (i.e., C71._). Meningiomas originate in the meninges, which are membranes that cover the brain and spinal cord.

Issue- Coding CS Lymph Nodes and CS Mets at Dx to "99" for in-situ tumors

Error Message states- Conflict among CS Extension, Lymph Nodes, and Mets at DX

By definition, an in-situ tumor is not yet invasive. Therefore, there cannot be involvement of regional lymph nodes, or metastases to a distant site. If a pathologist describes lymph nodes or distant sites as being involved with cancer, an area of invasion was missed and the tumor can no longer be categorized as in-situ.

Do not code "99" for CS Lymph Nodes or Mets at DX for an in-situ malignancy. Code both as "00."

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Issue- Overuse of C80.9 site code when a default site code can be used

Error message states- Site & Morphology conflict – ICDO3

Some histology/behavior terms in ICD-O-3 have a **related site code** in parenthesis; for example: hepatoma (C220).

a. Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.

Example: The pathology report says “ductal carcinoma of the head of the pancreas.” The listing in ICD-O-3 is ductal carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.

b. Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

Example 1: The biopsy is positive for hepatoma, but there is no information available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

Example 2: The patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 shows duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is

unknown, code the primary site as unknown (C809).

When the medical record does **not** contain **enough information** to assign a primary site:

a. Consult a physician advisor to assign the site code

b. Use the NOS category for the organ system or the Ill Defined Sites (C760-C768) if the physician advisor cannot identify a primary site,

c. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill Defined Site category.

Source: Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

For instance, if the differential diagnosis includes several sites, e.g., cholangiocarcinoma, lung, pancreas, and you cannot find any more specific information about the primary site in the patient’s record, go with site code C80.9.

Issue- Coding “CS Tumor Size” for an Unknown Primary

Error Message- Conflict among CS Tumor Size, Primary Site and Histologic Type ICD-O-3

SEER has clarified this issue:

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CODING CORNER— SPECIAL SECTION

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References

SPCSM 2004 ;pgs C-717

Question

CS Tumor Size--Unknown and Ill-defined Site: For an unknown primary site, should this field be coded to 000 [No mass/tumor found] or 999 [Unknown; size not stated; not stated in patient record]?

Answer

Code the CS Tumor Size field to 999 [Unknown; size not stated; not stated in patient record] when the primary site is unknown.

Additionally, I&R # 13639 on the College's web site, dated 12/8/2004, states:

Question

What is the code for CS Tumor Size if a patient had an unknown primary site, C80.9? The Collaborative Staging Manual page 27 says to code 888, but page 633 refers to the Standard Tables for Collaborative Staging Schemes code 999.

Answer

TS for unknown primary site is 999. General guidelines are in the process of being corrected.

Issue- Incorrect coding of CS Lymph Nodes with Pituitary Adenomas

Error message- Conflict among CS Lymph Nodes, Primary Site and Histologic Type ICD-O-3

Do not code CS Lymph Nodes to "00" for pituitary gland, even though this code is listed as an option. Note 2 above the CS Lymph Nodes item instructs: "Use code 99, not applicable, for the following sites: Pituitary gland (C75.1), Craniopharyngeal duct (C75.2), and Pineal gland (C75.3)."

The Collaborative Staging schema for pituitary gland includes several other endocrine sites, such as thymus and adrenal glands. Unlike some of these other sites, the pituitary gland does not have associated lymph nodes.

Issue- Incorrect coding of CS Extension for leukemias

Error message- Histologic type ICD-O-3 and CS Extension conflict

Code CS Extension to "80" for all leukemias, which by definition are disseminated disease.

Issue- Coding a WHO grade for CNS tumors

There are several grading systems for CNS tumors. Do not code a WHO grade for Site-specific factor 1 unless the grade is specifically stated to be a WHO grade. Additionally, the type of grading system needs to be stated in accompanying text documentation.

ICD-O-3 grade for benign CNS tumors is always coded to "9." (Data Collection of Primary Central Nervous System Tumors, page 35)

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CODING CORNER— SPECIAL SECTION

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Issue- Not Coding SSN's

Quality control activities for the most recent data submission have revealed a pattern of SSN's being coded to unknown. The Social Security Number is a very important data item for both hospital and central registries. Hospital registrars use the SSN for follow-up purposes. The ACR uses SSN's for linking records together.

Please remember to code a valid Social Security Number if it is available.

DATA SECTION

Your Data Hard at Work!

Liver Cancer

Introduction

Primary liver cancer begins in the cells of the liver itself and is often discovered late. Therefore, the prognosis is poor. In the United States, primary liver cancer is rare. Cancers that affect the liver are commonly metastatic cancers. Metastatic cancer occurs when tumors from other parts of the body spread to the liver. Cancers that most commonly spread to the liver include breast, colon, and lung.

Anatomy

The liver is a large organ that sits in the upper right portion of the abdomen just beneath the diaphragm and above the stomach. It normally weighs between 3.1 and 3.5 pounds. The liver is supplied with blood through the hepatic artery and the portal vein. It has a major role in metabolism and a number of functions in the body such as detoxifying the blood.

Risk Factors

Primary liver cancer can affect anyone regardless of age or race but certain factors may increase risk. Some of the factors that increase risk include:

- Chronic infection with HBV (hepatitis B virus) or HCV (hepatitis C virus)
- Sex
- Age
- Cirrhosis
- Diabetes
- Excessive alcohol consumption.
- Smoking

Chronic infection with HBV or HCV is the most important risk factor for cancer. Liver cancer is more likely to occur in males. In the United States the average age of diagnosis is 60 where in other parts of the world; such as Asia and Africa, the average age of diagnosis is as early as 20 years.

Cirrhosis causes scar tissue to form in the liver and increases the probability of developing liver cancer. People with diabetes have a much greater risk of developing liver cancer than people without diabetes. Consuming more than a moderate of amount of alcohol may lead to irreversible liver damage and increase the risk of liver cancer.

Liver Cancer in Arizona

From 1995-2005, 2,676 Arizona resident were diagnosed with liver cancer (Note: the 2005 data are 90% complete). The majority of cases occurred in males (70%). A large majority of cases occurred among Whites (90%) and Non-Hispanics (78%). The average age of diagnosis was 65 years.

The following tables represent Arizona resident cases diagnosed in the period 1995-2005. The 2005 data are 90% complete.

Race	Percent
White	89.6
Black	2.1
American Indian	4.9
Asian	3.0
Other/Unknown	.4

Ethnicity	Percent
Non-Hispanic	77.9
Hispanic	20.8
Unknown	1.3

Sex	Percent
Male	69.7
Female	30.3

(Continued on page 16)

DATA SECTION

Your Data Hard at Work!

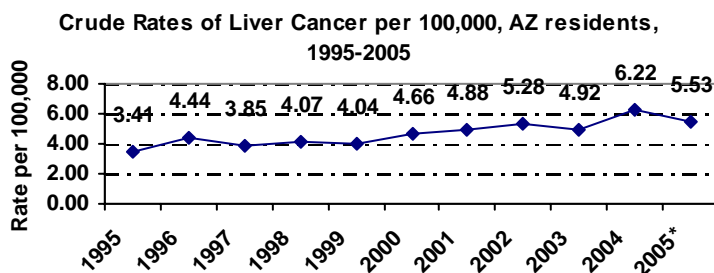
(Continued from page 15)

The most common types of liver cancers are hepatocellular carcinoma (HCC) and cholangiocarcinoma. In the U.S. HCC accounts for approximately sixty percent of liver cancers. Cholangiocarcinoma is a biliary tract malignancy that most commonly arises in the intra-hepatic, perihilar, or distal portions of the biliary tree. Cholangiocarcinoma accounts for approximately twenty percent of liver cancers. In Arizona, sixty-four percent of cases diagnosed between 1995 and 2005 were HCC and approximately nine percent of cases diagnosed in the same time period were cholangiocarcinoma.

Histology	Percent
Hepatocellular carcinoma	64.2
Cholangiocarcinoma	8.9
Other histologies	26.9

Incidence, 1995-2005

The rate of new cases of liver cancer in Arizona has been steadily rising. In 1995 the rate was low at 3.4 per 100,000 persons. The rate then jumped up to 4.4 followed by a sharp decrease to 3.8 per 100,000 in 1997. Since 1997, the rate of liver cancer has been on the rise. In 2004, the Arizona Cancer Registry recorded 363 new cases. This was the most number of cases reported to the registry for any year in the 1995-2005 time frame. In 2005, there is a sharp decline. However, the data for 2005 is not complete. Please use caution when interpreting the following graph.



References

1. Greene FL, et al. American Joint Committee on Cancer Staging Manual, 6th ed. Springer-Verlag; 2002.
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3. Liver Cancer. Mayo Clinic.com . Mayo Clinic Staff, 1/09/2008. Retrieved on 1/15/2008 from <http://www.mayoclinic.com/health/liver-cancer/DS00399>.
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DATA SECTION

Your Data Hard at Work!

United States Cancer Statistics 2004 Incidence and Mortality

This web based report includes the official federal statistics on cancer incidence from registries that have high-quality data and cancer mortality statistics for each year and 2002–2004 combined. It is produced by the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI), in collaboration with the North American Association of Central Cancer Registries (NAACCR).

Incidence data from 49 states, 6 metropolitan areas, and the District of Columbia are included in the report. The data obtained from National Program of Cancer Registries (NPCR) and Surveillance, Epidemiology, and End Results (SEER) registries in these areas cover approximately 98% of the U.S. population. Mortality data from the National Vital Statistics System (NVSS) are presented for all 50 states and the District of Columbia and therefore cover 100% of the U.S. population.

Cancer incidence and mortality statistics are reported for 68 selected primary cancer sites and subsites for men of all ages and 72 selected primary cancer sites and subsites for women of all ages.

Data are presented in tables and graphs in the following categories: 1) Geography: all U.S. combined, U.S. Census regions and divisions, states, and selected metropolitan areas; 2) Race and ethnicity: all races combined, whites, blacks, Asians/Pacific Islanders, American Indians/Alaska Natives, and Hispanics/Latinos.

You can view tables and graphs from the report, including state rankings for selected cancers and comparisons of state rates and national rates for selected cancers. Interestingly, Arizona had the

lowest cancer incidence rate overall (all sites and men and women combined) for 2004.

You may access the entire report and/or selected information taken from it at <http://apps.nccd.cdc.gov/uscs/>

Cancer Incidence in Five Continents, Volume IX

For an international perspective, check out volume IX of Cancer Incidence in Five Continents, (CI5) published by the International Agency for Research on Cancer (IARC). This volume presents incidence data from populations all over the world for which good quality data are available (including Arizona and other U.S. states). Cancer Incidence in Five Continents presents cancer incidence data for the years 1998-2002 from 300 populations, 225 cancer registries and 60 countries.

Scanning through the information gives a clear presentation of the cancer patterns worldwide. The tables that list cancer site-specific incidence rates by country and by regions/states within a country are particularly worth checking out. Even people who are not familiar with statistical concepts can get a snapshot of the cancer burden among countries all over the world simply by looking at the Age Standardized Rate (ASR) columns. For instance, a glance at the skin melanoma table shows that this disease is uncommon in the African nations that provided data to the report (e.g., 0.9 for males in Uganda). Compare this with the figure in the males ASR column for the Queensland state of Australia (55.8).

You can find these comparative tables, along with other sections of the report, at <http://www-dep.iarc.fr/>. A listing of the individual sections is on the left side of the page. The tables can be found under the “Summary Tables” heading.



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Cancer Registry Review

This document is published by the Arizona Department of Health Services, Bureau of Public Health Statistics, Office of Health Registries, Arizona Cancer Registry. It is intended to provide information and education for those who read it.

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If you need this publication in an alternative format, please contact the Arizona Cancer Registry at (602)542-7320.

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